SENATE COMMITTEE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 1695

AN ACT

To repeal sections 354.085, 354.405, 354.603 and 376.1219, RSMo, and to enact in lieu thereof seven new sections relating to health insurance.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 354.085, 354.405, 354.603 and 376.1219, RSMo, are repealed and seven new sections enacted in lieu thereof, to be known as sections 34.375, 354.085, 354.405, 354.603, 376.429, 376.1219 and 376.1253, to read as follows:

34.375. 1. This section shall be known and may be cited as the "Missouri Calcium Initiative".

2. The purchasing agent for any governmental entity that purchases food or beverages to be processed or served in a building or room owned or operated by such governmental entity shall give preference to foods and beverages that:

(1) Contain a higher level of calcium than products of the same type and quality; and

(2) Are equal to or lower in price than products of the same type and quality.

3. Notwithstanding the provisions of subsection 2 of this section to the contrary, if a state institution determines that a high calcium food or beverage that is preferred pursuant to

subsection 2 of this section will interfere with the proper treatment and care of a patient of such institution, the purchasing agent shall not be required to purchase the high calcium food or beverage for such patient.

4. The requirements of this section shall be in addition to any requirements placed upon a governmental entity by the United States Department of Agriculture under the National School Lunch Program or the School Breakfast Program.

5. For purposes of this section, "governmental entity" means the state of Missouri, its departments, agencies, boards, commissions and institutions, and all school districts of the state. Governmental entity does not include political subdivisions of the state.

6. Notwithstanding the provisions of this section to the contrary, a purchasing agent who has entered into a contract with a supplier before July 1, 2002, to purchase food and beverages shall not be required to purchase high calcium foods and beverages if purchasing such products would change the terms of the contract.

354.085. No corporation subject to the provisions of sections 354.010 to 354.380 shall deliver or issue for delivery in this state a form of membership contract, or any endorsement or rider thereto, until a copy of the form shall have been approved by the director. The director shall not approve any policy forms which are not in compliance with the provisions of sections 354.010 to 354.380 of this state, or which contain any provision which is deceptive, ambiguous or misleading, or which do not contain such words, phraseology, conditions and provisions

which are specific, certain and reasonably adequate to meet needed requirements for the protection of those insured. If a policy form is disapproved, the reasons therefor shall be stated in writing; a hearing shall be granted upon such disapproval, if so requested; provided, however, that such hearing shall be held no sooner than fifteen days following the request. The failure of the director of insurance to take action approving or disapproving a submitted policy form within [thirty] forty-five days from the date of filing shall be deemed an approval thereof [until such time as the director of insurance shall notify the submitting company, in writing, of his disapproval]. The director may not disapprove any deemed policy form for a period of twelve months thereafter. If at any time during such twelve-month period the director determines that any provision of the deemed policy form is contrary to statute, the director shall notify the health services corporation of the specific provision that is contrary to statute, and the specific statute to which the provision is contrary to, and may request, if the director determines it to be necessary and appropriate, that the health services corporation file within thirty days of receipt of the request an amendment form that modifies the provision to conform to statute. Upon approval of the amendment form by the director, the health services corporation shall issue a copy of the amendment to each individual and entity to which the deemed policy form was previously issued and shall attach a copy of the amendment to the deemed policy form when it is subsequently issued. Such amendment shall have the force and effect as if the amendment was in the original filing or policy. If the deemed

policy form is a certificate or other form issued to individual members, the health services corporation may fulfill its obligation to issue the conforming amendment to members to whom the deemed policy form was previously issued by either:

(1) For group coverage, supplying the group contract holder with a sufficient number of copies of the amendment so that the group contract holder may distribute a copy to each member to whom the deemed policy form was previously issued; or

(2) For group or individual coverage, including a copy of the amendment or a description of its contents in the health services corporation's next scheduled mailing to members.

The director of insurance shall have authority to make such reasonable rules and regulations concerning the filing and submission of such policy forms as are necessary, proper or advisable.

354.405. 1. Notwithstanding any law of this state to the contrary, any person may apply to the director for a certificate of authority to establish and operate a health maintenance organization in compliance with this act. No person shall establish or operate a health maintenance organization in this state without obtaining a certificate of authority pursuant to sections 354.400 to 354.636. A foreign corporation may qualify pursuant to sections 354.400 to 354.636, subject to its registration to do business in this state as a foreign corporation pursuant to chapter 351, RSMo, and compliance with the provisions of sections 354.400 to 354.636.

2. Every health maintenance organization doing business in this state on September 28, 1983, shall submit an application for

a certificate of authority pursuant to subsection 3 of this section within one hundred twenty days of September 28, 1983. Each such applicant may continue to operate until the director acts upon the application. In the event that an application is not submitted or is denied pursuant to section 354.410, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked. Any health maintenance organization licensed by the department of insurance prior to September 28, 1983, and complying with the paid-in capital or guarantee fund requirements of section 354.410 shall be issued a certificate of authority upon filing an amended certificate of authority and an amended articles of incorporation that conform with sections 354.400 to 354.636. When the annual statement of a health maintenance organization subject to the provisions of sections 354.400 to 354.636 is filed and all fees due from the health maintenance organization are tendered, the health maintenance organization's certificate of authority to do business in this state shall automatically be extended pending formal renewal by the director, or until such time as the director should refuse to renew the certificate.

3. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the director, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if the applicant is a corporation, and the partners or members if the applicant is a partnership or association;

(4) A copy of any contract made or to be made between any providers and persons listed in subdivision (3) of this subsection and the applicant;

(5) A copy of the form of evidence of coverage to be issued to the enrollees;

(6) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement shall be deemed to satisfy this requirement unless the director directs that additional or more recent financial information is required for the proper administration of sections 354.400 to 354.636;

(8) A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of

operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding;

(9) If the applicant is not domiciled in this state, a power of attorney duly executed by such applicant appointing the director, the director's successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(10) A statement reasonably describing the geographic area or areas to be served;

(11) A description of the complaints procedures to be utilized as required by section 354.445;

(12) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation;

(13) Evidence demonstrating that the health maintenance organization has provided its enrollees with adequate access to health care providers; and

(14) Such other information as the director may require to make the determinations required in section 354.410.

4. Every health maintenance organization shall file with the director notice of its intention to modify any of the procedures or information described in and required to be filed by this section. Such changes shall be filed with the director prior to the actual modification. <u>If a filing that is a document described in subdivision (4), (5), or (6) of subsection 3 of this</u>

section is disapproved, the reasons therefor shall be stated in writing and a hearing shall be granted upon such disapproval if so requested; provided that such hearing shall be held no sooner than fifteen days following the request. If the director does not approve or disapprove the modification within [thirty] forty-five days of filing, such modification shall be deemed approved. If a filing that is deemed approved is a document described in subdivision (4), (5) or (6) of subsection 3 of this section, the director may not disapprove the deemed filing for a period of twelve months thereafter. If at any time during that twelve-month period the director determines that any provision of the deemed filing is contrary to statute, the director shall notify the health maintenance organization of the specific provision that is contrary to statute, and the specific statute to which the provision is contrary to, and may request, if the director determines it to be necessary and appropriate, that the health maintenance organization file within thirty days of receipt of the request an amendment form that modifies the provision to conform to the state statute. Upon approval of the amendment form by the director, the health maintenance organization shall issue a copy of the amendment to each individual and entity to which the deemed filing was previously issued and shall attach a copy of the amendment to the deemed filing when it is subsequently issued. Such amendment shall have the force and effect as if the amendment was in the original filing or policy. If the deemed policy form is an evidence of coverage or other form issued to individual enrollees, the health maintenance organization may fulfill its obligation to issue the conforming

amendment to enrollees to whom the deemed policy form was previously issued by either:

(1) For group coverage, supplying the group contract holder with a sufficient number of copies of the amendment so that the group contract holder may distribute a copy to each enrollee to whom the deemed policy form was previously issued; or

(2) For group or individual coverage, including a copy of the amendment or a description of its contents in the health maintenance organization's next scheduled mailing to enrollees.

5. A health maintenance organization shall file all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto shall be filed and approved.

6. When the director deems it appropriate, the director may exempt any item from the filing requirements of this section.

354.603. 1. A health carrier shall maintain a network that is sufficient in number and types of providers to assure that all services to enrollees shall be accessible without unreasonable delay. In the case of emergency services, enrollees shall have access twenty-four hours per day, seven days per week. The health carrier's medical director shall be responsible for the sufficiency and supervision of the health carrier's network. Sufficiency shall be determined by the director in accordance with the requirements of this section and by reference to any reasonable criteria, including but not limited to, provider-enrollee ratios by specialty, primary care provider-enrollee ratios, geographic accessibility, reasonable

distance accessibility criteria for pharmacy and other services, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(1) In any case where the health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director.

(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers, including local pharmacists, to the business or personal residence of enrollees. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under, especially rural areas, consideration.

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its providers to furnish all contracted benefits to enrollees. The provisions of this subdivision shall not be construed to require any health care provider to submit copies of such health care provider's income tax returns to a health carrier. A health carrier may require a health care provider to obtain audited financial statements if such health care provider received ten percent or more of the total medical expenditures made by the

health carrier.

(4) A health carrier shall make its entire network available to all enrollees unless a contract holder has agreed in writing to a different or reduced network.

2. A health carrier shall file with the director, in a manner and form defined by rule of the department of insurance, an access plan meeting the requirements of sections 354.600 to 354.636 for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information will cause the health carrier's competitors to obtain valuable business information. The health carrier shall provide such plans, absent any information deemed by the director to be proprietary, to any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any change as defined by the director to an existing managed care plan. The director shall approve or disapprove the access plan, or any subsequent alterations to the access plan, within sixty days of filing. The access plan shall describe or contain at a minimum the following:

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(3) The health carrier's process for monitoring and

assuring on an ongoing basis the sufficiency of the network to meet the health care needs of enrollees of the managed care plan;

(4) The health carrier's methods for assessing the health care needs of enrollees and their satisfaction with services;

(5) The health carrier's method of informing enrollees of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(6) The health carrier's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(7) The health carrier's process for enabling enrollees to change primary care professionals;

(8) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, in the event of a reduction in service area or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees shall be notified of the contract termination, reduction in service area or the health carrier's insolvency or other modification or cessation of operations, and transferred to other health care professionals in a timely manner; and

(9) Any other information required by the director to determine compliance with the provisions of sections 354.600 to

354.636.

3. In reviewing an access plan filed pursuant to subsection 2 of this section, the director shall deem a managed care plan's network to be adequate if, in lieu of the network information required by subdivision (1) of subsection 2 of this section, the health carrier submits a sworn affidavit signed by an officer of the health carrier stating that it meets one or more of the following criteria:

(1) The managed care plan is a Medicare + Choice coordinated care plan offered by the health carrier pursuant to a contract with the Federal Centers for Medicare and Medicaid Services;

(2) The managed care plan is being offered by a health carrier that has been accredited by the National Committee for Quality Assurance at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed;

(3) The managed care plan's network has been accredited by the Joint Commission on the Accreditation of Health Organizations at a level of "accreditation without type I recommendations" or better, and such accreditation is in effect at the time the access plan is filed. If the accreditation applies to only a portion of the managed care plan's network, only the accredited portion will be deemed adequate; or

(4) The managed care plan network is accredited by any other accrediting organization that is approved by the Missouri department of insurance.

376.429. 1. All health benefit plans, as defined in section 376.1350, that are delivered, issued for delivery,

continued or renewed on or after August 28, 2002, and providing coverage to any resident of this state shall provide coverage for routine patient care costs as defined in subsection 6 of this section incurred as the result of phase III or IV of a clinical trial that is approved by an entity listed in subsection 4 of this section and is undertaken for the purposes of the prevention, early detection, or treatment of cancer.

2. In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

3. Coverage required by this section shall include coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

4. Subsections 1 and 2 of this section requiring coverage for routine patient care costs shall apply to clinical trials that are approved or funded by one of the following entities:

(1) One of the National Institutes of Health (NIH);

(2) An NIH Cooperative Group or Center as defined in

subsection 7 of this section;

(3) The FDA in the form of an investigational new drug application;

(4) The federal Departments of Veterans' Affairs or Defense;

(5) An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or

(6) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

5. An entity seeking coverage for treatment, prevention, or early detection in a clinical trial approved by an institutional review board under subdivision (5) of subsection 4 of this section shall maintain and post electronically a list of the clinical trials meeting the requirements of subsections 2 and 3 of this section. This list shall include: the phase for which the clinical trial is approved; the entity approving the trial; whether the trial is for the treatment of cancer or other serious or life threatening disease, and if not cancer, the particular disease; and the number of participants in the trial. If the electronic posting is not practical, the entity seeking coverage shall periodically provide payers and providers in the state with a written list of trials providing the information required in this section.

6. As used in this section, the following terms shall mean:

(1) "Cooperative group", a formal network of facilities that collaborate on research projects and have an established

NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

(2) "Multiple project assurance contract", a contract between an institution and the federal Department of Health and Human Services (DHHS) that defines the relationship of the institution to the DHHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects;

(3) "Routine patient care costs", shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

(a) The investigational item or service itself;

(b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

(c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

7. For the purpose of this section, providers participating in clinical trials shall obtain a patient's informed consent for participation on the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to the health insurer upon request.

8. The provisions of this section shall not apply to a

policy, plan or contract paid under Title XVIII or Title XIX of the Social Security Act.

376.1219. 1. Each policy issued by an entity offering individual and group health insurance which provides coverage on an expense-incurred basis, individual and group health service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group health arrangements to the extent not preempted by federal law, and all health care plans provided by managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed in this state on or after September 1, 1997, shall provide coverage for formula and low protein modified food products recommended by a physician for the treatment of a patient with phenylketonuria or any inherited disease of amino and organic acids who is covered under the policy, contract, or plan and who is less than six years of age.

2. **[**The health care service required by this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the policy, contract or plan.**]** For purposes of this section, "low protein modified food products" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

3. The coverage required by this section may be subject to the same deductible for similar health care services provided by

the policy, contract, or plan as well as a reasonable coinsurance or copayment on the part of the insured, which shall not be greater than fifty percent of the cost of the formula and food products, and may be subject to an annual benefit maximum of not less than five thousand dollars per covered child. Nothing in this section shall prohibit a carrier from using individual case management or from contracting with vendors of the formula and food products.

[3.] 4. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, or any other supplemental policy as determined by the director of the department of insurance.

376.1253. 1. Each physician attending any patient with a newly diagnosed cancer shall inform the patient that the patient has the right to a timely referral for a second opinion by an appropriate board certified specialist, prior to any treatment. If no specialist in that specific cancer diagnosis area is in the provider network, a referral shall be made to a nonnetwork specialist in accordance with this section.

2. Each health carrier or health benefit plan, as defined in section 376.1350, that offers or issues health benefit plans which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2003, shall provide coverage for a second opinion rendered by a specialist in that specific cancer diagnosis area when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending

physician. Such coverage shall be subject to the same deductible and coinsurance conditions applied to other specialist referrals and all other terms and conditions applicable to other benefits, including the prior authorization and/or referral authorization requirements as specified in the applicable health insurance policy.

3. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance.